Developmental Disabilities Administration
Low Intensity Support Services (LISS) Request Form

APPLICANT INFORMATION

Last Name:	First:	Middle:	Marital Status (circle one) Single Married Div Sep Widow	
Address:	City: County:	State:	Zip Code:	Sex: M / F

Cell Phone #	Day/Work #	Home #
Email Address: (If applicable)		
Social Security #:	Date of Birth:	Age:
Medical Assistance #: If none, date of application (For applicant over the age of 18):		

Demographic Information - (for internal use only - does not apply to eligibility)

Individual's Annual Income (optional): Household Annual Income (optional):

Primary Disability:

Race(circle one): Black/African American White/Caucasian Asian Hispanic Other American Indian/Alaska Native American Pacific

What is the relationship of the person completing this form to the applicant? ___ Self ___ Parent ___Spouse ___Guardian ___Resource/Service Coordinator ___School Counselor ___Other :

If not "self", please note name of person completing this form: Phone #:

Please check all programs and services the applicant is currently receiving services or resources from:

DDA:
____ Resource/Service Coordination
____ Day/Supported Employment
____ CSLA
____ Supports
____ Community Pathways or New Directions

MA Waivers:
___ Autism
___ Model
___Traumatic Brain Injury
___ Living at Home
___Older Adults
___ Medical Day Care
___ RTC (Residential Treatment Center)
___ REM (Rare & Expensive Case Management)
___ MA Personal Care
___ In-Home Aid Services (DSS)
___ Attendant Care Program

OTHERS:
___ Special Education
___ Division of Rehabilitation Services (DORS)
___ Food Bank
___ Transportation
___ Social Services
___Energy Assistance (MEAP)
___Housing
___ Other:

Resource/Service Coordinator/Case Manager Name:	Phone #:
Address:	Email:

SERVICE/ITEM REQUEST

Eligible Support/ Activity/ Item	Name, Address & Telephone # of Provider of Support/Activity/Item (To whom the payment is made)	Cost of Support/ Activity/ Item	Dates of Support/ Activity	Documentation of cost (This must be included)	FOR RESPITE REQUEST ONLY □ NAME OF PROVIDER □ DAILY RATE □ AMOUNT OF DAYS
EXAMPLE: -Summer Camp	ABC CAMP 123 Any Way Anywhere, MD 12345 410-222-2222	$660.00	June 20 – August 25	YES	
1.					
2.					
3.					

Where else has funding been sought and the status? (i.e. application pending, denied, or the amount funded)

1.	
2.	
3.	
Applicant's Contribution (if any):	

APPLICANTS ARE REQUIRED TO SUBMIT APPROPRIATE DOCUMENTATION INCLUDING A COPY OF THE SOCIAL SECURITY CARD, PROOF OF RESIDENCY, AND PROOF OF DEVELOPMENTAL DISABILITY IN ORDER FOR ELIGIBILTY TO BE CONSIDERED.

Applicant Declaration

By signing this application, I hereby attest that the information provided to process the Low Intensity Support Services (LISS) funding request is accurate to the best of my knowledge. I understand LISS funding is not an entitlement program, and receipt of LISS funds is on a first come, first serve basis. LISS funding is contingent upon DDA's LISS eligibility criteria, verification of the above information, and funding availability.

Signature of Applicant:_____ Date:_____
Name (Print): _____

Person designated to receive
correspondence:_____ Date:_____
Name (Print): _____

Form Effective 7/1/2011